**State of California**
**Department of Industrial Relations**
**Self Insurance Plans**
**2265 Watt Avenue, Suite 1**
**Sacramento, CA 95825**
Phone (916) 483-3392
FAX (916) 483-1535



Our File: ☐☐☐☐

# APPLICATION FOR A CERTIFICATE OF CONSENT TO ADMINISTER WORKERS' COMPENSATION SELF INSURANCE CLAIMS

INSTRUCTIONS: All questions below must be answered. If not applicable, enter "N/A".

The undersigned administrative agency hereby applies for a Certificate of Consent to Administer workers' compensation claims for permissibly self-insured employers in accordance with the provisions of California Labor Code Section 3702.1.

**1.** Date: _____

**2**. Type of Application:

☐ New ☐ Addition of Reporting Location(s) Only

☐ Renewal of Existing Certificate to Administer No.: ☐☐☐☐

**3.** Name of Administrative Agency: _____

Street Address: _____

Mail Address: _____

City: _____ State: _____ Zip: _____

**4.** Type of Entity:

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ JPA

**5.** Is the applicant a workers' compensation insurance carrier? ☐ Yes ☐ No

If yes, is the applicant a separate subsidiary to administer claims? ☐ Yes ☐ No

**6.** Name of Owner(s): _____

**7.** List the manager's name and adjusting location addresses and phone numbers below:

1. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ FAX: (____) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

**7.** (Continued) List the manager's name and adjusting location addresses and phone numbers below:

2. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

3. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

4. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

5. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

**7.** (Continued) List the manager's name and adjusting location addresses and phone numbers below:

6. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

7. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

8. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

9. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

**7.** (Continued) List the manager's name and adjusting location addresses and phone numbers below:

10. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ FAX: (  ) _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

**8.** List below the name of the city of each adjusting location in number 7 above; then the name of each self-insured employer serviced at that adjusting location; the number of the Certificate to Self Insure for each self-insured employer; and the name of the claims adjuster—who has demonstrated their individual competence by passing the Self Insurance Administrator's examination—who is responsible for the self insurer's claims at that adjusting location:

| Adjusting Location (City) | Name of Self-insured Employer | Certificate Number | Name of Competent Person |
|---|---|---|---|
| | | | |

**8.** (Continued)

| Adjusting Location (City) | Name of Self-insured Employer | Certificate Number | Name of Competent Person |
|---|---|---|---|
| | | | |

**9.** Period of Time for Certificate Issuance Requested:

☐ 1 Year ☐ 2 Years ☐ 3 Years

**10.** Fees Due with this Application (not applicable to joint powers authorities and insurance carriers):

(a) Base Fee $650 for each Administrative Agency per year (includes initial adjusting location):

$650 x _____ years = $ _____

(b) Adjusting Location Fee of $100 for second and subsequent adjusting locations per year:

$100 x _____ additional locations x years = $ _____

(c) Fees Submitted with Application: $ _____

The information submitted in this application is true and correct to the best of my knowledge.

Signature of Person Completing Application: _____

Typed Name of Person Completing Application: _____

Title of Person Completing Application: _____

Phone number: (_____) _____

Date: _____